Pain on injection of subconjunctival antibiotics during cataract surgery under local anaesthesia

Dr Carolyn Johnston
Dr Monica Hardwick and Dr Jo Budd
Department of Anaesthesia, Worcestershire Royal Hospital

Introduction

Local experience suggested that patients undergoing cataract surgery under sub Tenon’s local anaesthesia experienced significantly more pain during injection of antibiotic at the end of surgery than those under peribulbar block.

To test this hypothesis, we undertook a prospective audit of pain scores during the administration of antibiotics by subconjunctival injection at the end of surgery under local anaesthetic block.

Methods

Fifty consecutive patients were recruited, and surgery was performed by the same surgeon. The patients were divided into subTenon’s and peribulbar anaesthesia groups, depending on the day of surgery- with some patients crossing groups for surgery on the second eye. Anaesthesia was provided by one consultant anaesthetist for each group, or a trainee under that consultant’s supervision. Pain was assessed using a numerical scale and recorded by clinic nurses in the recovery room immediately after surgery. The data recorded is listed in table 1. Statistical analysis was done using Mann Whitney U test comparing two sets of non-parametric data, giving a two-tailed p value. Significance was inferred with a P value of <0.05.

Table 1

<table>
<thead>
<tr>
<th>Type of Block (peribulbar/sub Tenon’s)</th>
<th>Pain during anaesthesia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local anaesthetic (type and volume)</td>
<td>Pain during surgery</td>
</tr>
<tr>
<td>Additions to LA (Hyaluronidase/adrenaline)</td>
<td>Pain during antibiotic injection</td>
</tr>
<tr>
<td>Globe akinesia</td>
<td>Time in theatre</td>
</tr>
<tr>
<td>Requirement for top up</td>
<td>Complications</td>
</tr>
</tbody>
</table>

Results

24 patients received peribulbar blocks and 26 patients sub Tenon’s. The Anaesthetic technique was consistent within the groups.

Both groups received topical proxymetacaine and amethocaine drops. SubTenon’s patients received 5mls of 2% lidocaine with 1:200,000 adrenaline and 75u/ml hyaluronidase via an inferomedial Visitec SubTenon’s cannula. Peribulbar patients received a subconjunctival injection of 0.4% lidocaine and 10mls 2% locaine with 1:200,000 adrenaline via a 25G, mm needle using medial canthus and lateral incisions. Only one patient required anaesthetic...
“top-up” prior to surgery, all others had globe akinesia scored at less than 2/5 in all 4 quadrants. Further local anaesthetic was not administered by the surgeon during surgery. No major complications were encountered. Scores are shown in table 2 and figure 1.

### Table 2

<table>
<thead>
<tr>
<th></th>
<th>SubTenons</th>
<th>Peribulbar</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Med</td>
</tr>
<tr>
<td>Time in theatres</td>
<td>37.35 mins</td>
<td>20-55 mins (range)</td>
</tr>
<tr>
<td>Pain during anaesthesia</td>
<td>0.5</td>
<td>0 (0-0)</td>
</tr>
<tr>
<td>Pain during surgery</td>
<td>0</td>
<td>0 (0-0)</td>
</tr>
<tr>
<td>Pain during anaesthetic injection</td>
<td>0.77</td>
<td>1.5 (1.5)</td>
</tr>
</tbody>
</table>

We would be interested to know if our patient’s experiences are shared at other centres and any strategies used to alleviate the problem.

### References


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**Conclusions**

We have been able to prove a difference between the perception of pain at the end of surgery between subTenon’s and peribulbar anaesthesia. A search of the literature does not indicate a reproducible difference in the offset of the two blocks. However, the length of surgery is relatively long for extra capsular phacoemulsification, and may account for pain at the end of the procedure.

**Intranasal remifentanil in painful ophthalmic outpatient procedures – report of a pilot study**

Stephen J. Mather¹, Richard H. Markham², Eric Mayer³ and Maria Macipe⁴

1. Consultant in anaesthesia and perioperative medicine
2. Consultant in ophthalmology
3. Senior Lecturer in ophthalmology
4. Associate Specialist in ophthalmology

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Chandra.kumar@stees.nhs.uk  Website http://www.boas.org

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Bristol Eye Hospital
Lower Maudlin Street
Bristol, United Kingdom

**Introduction**

This study was designed to find out whether remifentanil, administered as a nasal spray, could relieve the discomfort of procedures such as panretinal photocoagulation for proliferative diabetic retinopathy and cryotherapy for peripheral retinal holes.
There was no statistical difference between the group’s length of surgery (p=0.095), pain during anaesthesia (p=0.99) and pain during surgery (p=1).

No correlation was found between time in theatre and antibiotic injection pain score, although this may be a feature of the small sample size.

There was a statistically significant difference between pain on injection of antibiotic in the two groups, with patients having sub Tenon’s anaesthesia more likely to experience pain, p=0.033.

**Figure 1 proliferative diabetic retinopathy**

![Image of proliferative diabetic retinopathy](image1)

**Figure 2. retinal photocoagulation**

![Image of retinal photocoagulation](image2)

Preoperative non-steroidal anti-inflammatory drugs, paracetamol and weak opioid analgesics are inadequate. Conventional opioids (morphine, pethidine) given by intramuscular injection delay discharge and may cause postoperative nausea and vomiting.

We perceived the need for a short acting, potent analgesic, with rapid onset and offset, allowing patients to be discharged from hospital within one hour. The agent used must not cause significant respiratory depression nor postoperative nausea or vomiting.

Currently, the discomfort of these procedures is either ignored completely, the only analgesia being provided by surface drops, for placement of a contact lens, or provided by regional orbital anaesthesia (peribulbar, retrobulbar or sub-Tenon’s injection). Neither of these approaches is satisfactory since the drops provide no analgesia for the procedure, and, if necessary, orbital anaesthesia is carried out by the operator working alone, with the patient otherwise unobserved in a darkened room. An anaesthetist is not usually present, nor can rapid attendance be guaranteed in the event of complications from the block. The commonest of these are vaso-vagal hypotension and angina, which occur even with sub-Tenon’s block.

Any technique which is employed should be suitable for out-patient clinic rooms. It should be applicable without the need for immediate anaesthetic assistance and the dose should ideally be controlled by the patient.

**Remifentanil**

Remifentanil is a potent opioid analgesic which has been used for some years in anaesthetic practice. It is unique among opioid analgesics in current use in being hydrolysed in the plasma by non-specific esterases. Its half-life is 5 – 7 minutes, but repeated doses are not cumulative and it is effectively not context-sensitive, even when given by intravenous infusion, the method commonly employed for its administration during general anaesthesia. It is relatively lipid soluble and this property would suit administration by the nasal route, the drug being
rapidly transferred across the nasal mucosa into the circulation. The short half life ensures fast offset of effect.

Methods

The study was approved by the local research ethics committee. After obtaining informed consent, a small group of 5 patients were recruited into the pilot study. These patients were asked to record pain scores using a visual analogue score. In this group, no analgesia, apart from surface drops, was provided. This was to allow the investigators to gain familiarity with the pain scoring method.

Remifentanil solution was prepared by the hospital pharmacy and quality control was carried out by HPLC assay for remifentanil and degradation products at monthly intervals for 12 weeks. The solution is stable if stored in a refrigerator (5 degrees Celsius) for this period. In the next group of 15 patients, consent for the procedure had been obtained at the time of listing in the outpatient clinic, and all patients had time to consider whether or not they wished to participate in the study.

Monitoring consisted of non-invasive blood pressure and pulse oximetry. A cannula was placed in a peripheral vein. The pain scoring system was explained prior to the procedure. An intranasal spray of either 25 or 50 micrograms of remifentanil, administered from a metered dose atomiser, was given (in a double-blind fashion for dose) prior to the procedure. The procedure was started approximately 2 minutes later.

Patients were asked to indicate whether any analgesic effect was wearing off, when a further dose was offered. There was no limit to the number of demands the patient could make. At the end of the procedure, the pain score was obtained immediately.

Results

Five patients underwent pan-retinal photocoagulation with no analgesia and rated their pain score according to protocol. All received a minimum of 500 retinal burns. Pain scores ranged from 2.0 to 8.0 However, in all cases the laser was tolerated and the treatment completed (table 1)

Table 1. Control patients – no analgesia

<table>
<thead>
<tr>
<th>Patient number</th>
<th>Pain score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6.0</td>
</tr>
<tr>
<td>2</td>
<td>3.0</td>
</tr>
<tr>
<td>3</td>
<td>2.0</td>
</tr>
<tr>
<td>4</td>
<td>7.0</td>
</tr>
<tr>
<td>5</td>
<td>8.0</td>
</tr>
</tbody>
</table>

A further 12 patients completed the study and received intranasal remifentanil in doses varying from 100 to 875 micrograms. Pain scores varied from 0.3 to 6.1 in this group (Table 2). No patient suffered nausea or vomiting. Two patients reported a feeling of “light-headedness”. Haemoglobin saturation remained above 93% in all patients, who breathed room air.

Table 2. Remifentanil dose and pain score

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Chandra.kumar@stees.nhs.uk  Website http://www.boas.org |
A trend is apparent in that patients who had received larger total doses of remifentanil had lower pain scores. All patients who received remefentanil remifentanil expressed satisfaction with the method, and three asked to have it again, should they require further treatment.

The results are plotted graphically in figure 3.

**Conclusion**

The results suggest that patients who received the larger doses of remifentanil had lower pain scores. Intranasal remifentanil was acceptable to all patients. No patient suffered unacceptable oxygen desaturation nor developed postoperative nausea or vomiting. The study is too small to reach a firm conclusion but the results suggest that this method of analgesia deserves further investigation in a larger trial.
Publication of this newsletter has been possible by a generous donation from

Abbott Laboratories Ltd
Queenborough
Kent, ME11 5EL
Trainees eye view
Dr Steve Mathieu
Senior House Officer Anaesthetics

Dr Dan Dalgleish
Consultant Anaesthetist
Poole General Hospital

With both the impending modernisation of medical careers starting in earnest in August ¹, and also the reduction on junior doctors working hours ², there is a growing necessity to increase the efficiency of training.

Currently, Senior House Officers in Anaesthetics in this region will probably not be involved in enough eye lists to give them anything but the barest of tastes for the discipline. They will, on occasion, be providing a service commitment with no senior anaesthetist present. On these operating lists, the surgeon will often be more proficient at eye blocks, meaning the junior anaesthetist’s role becomes one of helping the list to run more efficiently taking the lead only when resuscitation is required.

In the latter part of 2005 the foundation courses will commence. If we are to have any opportunities to encourage doctors to embark upon a career in anaesthesia, then perhaps eye lists, which frequently involve regional blocks only, are too specialised. More importantly, if a foundation course rotation includes anaesthesia, then it is imperative that as much time as possible is spent gaining the resuscitation skills that we as anaesthetists consider second nature. Possessing these most basic skills is not only important for those progressing to registrar training in anaesthesia, but also for those who decide to pursue an alternative career. The ability to manage an airway, obtain difficult peripheral access and perform central venous cannulation are skills that are vital in all hospital settings particularly since the introduction of the ‘Hospital at Night’ ³ which has led to only a skeleton staff being available for large stretches of time.

If trainees are to be able to develop an interest in a sub speciality within anaesthesia (such as Ophthalmic Anaesthesia) then it is essential to have enough clinical exposure. It will require a careful balance in order to ensure that the anaesthetists of the future are well equipped to provide a high quality service for the broad spectrum of general cases but also to allow them to develop subspeciality interests. The next seven years when we see the first foundation doctors emerge as consultants will be fascinating. The hope is that despite a shorter training period, they will have had sufficient time to be successful in both the breadth and depth of their field. Sadly we feel that this is unrealistic and it may be that in the future we see doctors specialising further after they have achieved their Certificate of Competency Training (CCT). Perhaps the limited availability of subspecialty lists should be restricted to more senior trainees who may commit themselves to ophthalmic anaesthesia.

References

1 Modernising medical careers: the next steps. The future shape of Foundation, Specialist and General Practice Training Programmes. Department of Health. 2004
The Hospital at Night. MacDonald R. BMJ Career Focus 2004; 328
The role of the anaesthetist in cataract surgery under local anaesthesia

Dr Anthony Rubin
Wellington Eye Unit, London

The role of the anaesthetist in cataract surgery carried out under local anaesthesia is often questioned. Up to around 1990, most ophthalmic surgery in the UK was done under general anaesthesia. Local anaesthesia was used only for those cases where the anaesthetist deemed the patient unfit for general anaesthesia. These cases were usually put on the end of the list so the anaesthetist could be released to attend to other pressing matters. However some surgeons, especially if less skilled in local anaesthesia, demanded the anaesthetist to provide a patient in a state indistinguishable from general anaesthesia. This was to cover the poor block result and the surgeon’s unfamiliarity with operating under local anaesthesia. This was clearly the worst possible scenario for the patient, who was likely to develop airway problems, oxygen desaturation and hypercapnia, and who would have been better served by having a controlled general anaesthetic from the beginning!

By 1990 it was apparent that the majority of cataract surgery in the United States and many other countries was being done under local anaesthesia, and it was suggested that we might consider following their example. As 80% of these patients are 70 years of age or over, and 57% have pre-existing medical problems, local anaesthesia seemed to be the preferable option, particularly for small incision surgery. One would expect local anaesthesia to be associated with lower morbidity and least disruption to daily routine. Courses using video links were run at Charing Cross Hospital, Middlesbrough and other locations to teach the techniques that achieved popularity and widespread usage surprisingly rapidly. The use of local anaesthesia rose from 20% in 1991 to over 95% in 2003, while the use of sedation dropped from 45% to under 4%. In 1991, the local anaesthesia was almost entirely by sharp needle, especially peribulbar, block which was considered to be safer than the traditional retrobulbar block. In most centres the anaesthetists, encouraged by many surgeons, rapidly took over the administration of the local anaesthesia and so their presence at these lists was not questioned. The Joint Colleges guidelines of 1993 stated clearly “an anaesthetist should be present in order to give resuscitation, should it be required, and to arrange for the monitoring of the patient’s general condition throughout the operation. The anaesthetist would also be responsible for advising where appropriate on whether or not a particular patient would benefit most from local or general anaesthesia, prescribing sedation if thought necessary, giving the local anaesthetic block and providing intravenous access, and supervising the patient’s postoperative recovery.”

Figures for the incidence of serious systemic adverse events are sparse but have been estimated at 3.4 per 10,000, although a degree of under-reporting was suspected. We believe that these events are not reduced by pre-operative investigations.

Inevitably the widespread interest in local anaesthesia and changes in surgical technique resulted in modifications in block techniques and of particular interest and significance was the rapid rise in the use of topical and sub-Tenon’s blocks which taken together have rather overtaken the use of sharp needle blocks. This resulted from concerns about the very occasional serious complication of sharp needle blocks, viz. globe perforation, retrobulbar haemorrhage, direct or indirect damage to the optic nerve, or central spread of local anaesthetic. Recent unpublished data suggest that both globe perforations and brain stem anaesthesia continue to occur with needle blocks. The incidence of these complications can only be reduced by improvements in training and supervision of trainees, and the employment of experienced...
practitioners wherever possible. However it is apparent that no local anaesthetic technique is totally free from the risk of a serious systemic event, some of these resulting from pre-existing medical conditions, anxiety, pain or the stress reaction to the surgery.

By 2001 it had been decided to update the joint College guidelines to take into account the considerable experience gained and the changes in the usage of different local anaesthetic techniques. The latest joint College guidelines support the concept that there is no need for an anaesthetist to be present if the surgery is being done under topical or sub-Tenon’s block without sedation. However it remains an essential recommendation that “All theatre personnel should have regular training in Basic Life Support (BLS), and there should be at least one person present with Advanced Life Support (ALS) or equivalent qualification”.

So where are we today and who should administer the local anaesthetic? The choice of anaesthetic is usually decided by those nurses or surgeons who see, assess and schedule the patients for surgery as most will not meet an anaesthetist until the day of surgery itself, if at all. This is not ideal as nurses and surgeons may not be as skilled as anaesthetists in selecting the optimal method of anaesthesia for the individual patient, which depends on age, level of anxiety, pain threshold, ability to lie fairly flat and still, the particular features of the globe and orbit, the skill of the anaesthetist and surgeon, and the difficulty of the surgery. Ophthalmic surgeons in particular have rather fixed ideas about anaesthesia, leaning heavily on one technique with which they are particularly familiar, rather than offering a variety of techniques and tailoring it to the requirements of the individual patient. The latest cataract guidelines of the Royal College of Ophthalmologists state “Nurses, technicians and others may be trained to administer topical, or subconjunctival or sub-Tenon’s anaesthesia. In some centres, nurses have been trained to administer sub-Tenon’s blocks, but the administration by these professionals of peribulbar or retrobulbar injections is not recommended”.

There is increasing evidence that patients experience more pain under topical than sub-Tenon’s block, peribulbar or retrobulbar blocks. Patients scheduled for topical anaesthesia should be warned about the pain or discomfort that they might experience during the surgery. I have the distinct feeling that the cult towards “minimal invasion” that has overcome eye surgeons has been carried into their choice of anaesthesia. Thus invasive methods of anaesthesia with morbidity much lower than the cataract operation itself are being rejected in favour of less effective methods. Out of 61 claims reported in one review, only 9 were associated with complications of local anaesthetic techniques while 5 involved excessive pain. The remaining 47 related to other complications of the surgery.

If the anaesthetist is administering the local anaesthetic by whatever method, of course they will be present during the list to care personally for each patient. Similarly if sedation is required, the anaesthetist should administer it, and monitor its effects. The need for sedation is reduced if good pre-operative assessment and counselling is provided, and painless local anaesthetic techniques are used (more often practised by anaesthetists than surgeons). The provision of verbal support and reassurance, and the availability of a hand-holder during the surgery all improve the patient’s experience of the surgery.

However if the surgeon or nurse administers the local anaesthetic, I believe that they must take full responsibility for it with respect to efficacy and safety. It is unacceptable to have an anaesthetist sitting with a patient who may have inadequate anaesthesia for which the anaesthetist is powerless to act appropriately to remedy the situation! The patient will inevitably and understandably point the finger at the
anaesthetist rather than the surgeon or nurse if there are anaesthetic deficiencies. I do not consider, and this is confirmed in the RCO cataract guidelines, that the use of intravenous sedatives to cover poorly administered or poorly functioning local anaesthesia is an acceptable solution.

In conclusion, the patient is surely best served by the presence of an anaesthetist who has a variety of techniques at his disposal and can tailor the technique to the needs of the individual patient and surgeon. If the surgeon or nurse wishes to take on the responsibility for the administration of the anaesthetic, the anaesthetist should wish them well and go elsewhere where his skills are needed and more appreciated.

References

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Chandra.kumar@stees.nhs.uk   Website http://www.boas.org
Invitation to annual scientific meeting of BOAS, 27-28th October 2005

I would like to invite you to the first offshore meeting of BOAS in Jersey on 27 &28th October. With the help of other BOAS Council members, I have put together a varied programme, which I hope you will find of interest.

The meeting will be held in the Postgraduate Centre at the General Hospital. We can accommodate 90 people and I advise you to apply early if you wish to secure a place.

There are two sessions for delegates to present papers. Firstly, there is a 'problematic case session' where you can tell us about ophthalmic anaesthesia cases which have presented significant challenges, and secondly we have the free paper session for the presentation of research studies, audits etc. The highlight of the meeting will be the Abbott Lecture given by Jacques Ripart from France.

I look forward to welcoming you to Jersey. The main tourist season will be over by late October and the Island will be a bit quieter. One advantage of coming at this time of year is that the Channel Island Tennerfest will be running. Many of the restaurants on the Island will be offering cut-price menus. Jersey is renowned for its fish and seafood and you can enjoy excellent cuisine at a considerable saving.

I enclose the programme, the registration form, paper abstract forms and some information on travel and accommodation. The Revere has been designated as the main conference hotel. It is right next door to the hospital and Postgraduate Centre. As there only about 50 rooms at the Revere, you are strongly advised to apply if you wish to stay there. The Island has plenty of other hotels.

Looking forward to seeing you in Jersey,

Yours sincerely,

Bartley McNeela
Meeting Organiser
Annual Meeting
Postgraduate Centre, General Hospital, Jersey, Channel Islands
27th and 28th October 2005

Registration form:

Surname: ____________________________

Forename(s): ________________________

Title (Professor, Dr etc.): ______________

Address: ______________________________

Telephone: ___________________________

Fax: _________________________________

Email: ________________________________

<table>
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<th>Registration fee</th>
<th>BOAS member</th>
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<td><strong>Total</strong></td>
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Seafood and fish will be the main theme for the dinner. If you prefer meat or vegetarian dishes, please tick the appropriate box:

[ ] Meat dishes

[ ] Vegetarian

I enclose a cheque for ________ payable to ‘Treasurer of the States – BOAS 2005’

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Chirocaine is a local anaesthetic agent that is indicated for various procedures, including surgery, dentistry, and obstetrics.
Abstract form for ‘problematic’ clinical case presentation

I wish to submit a case presentation for inclusion in the
‘Problems in ophthalmic anaesthesia’ session

The number of presentations of problematic cases is limited to 8, and will be subject to review before acceptance. Each oral presentation should last 5 minutes. There will be time for discussion afterwards.

Name: 
Address: 

Tel:    Fax: 

Email: 

Please type abstract in box below:
Abstract form for free paper/poster

I wish to submit a paper for:

Oral presentation*

Poster presentation

*Oral presentations of free papers are limited to 6 and should last for 10 minutes. Each paper will be subject to review before acceptance. If your paper is not accepted for oral presentation, you will be invited to submit it as a poster.

Name: 
Address: 
Tel: 
Fax: 
Email: 

Please type abstract in the box below:
Annual Meeting

Postgraduate Centre, General Hospital, Jersey, Channel Islands
27th and 28th October 2005

Thursday 27 October

13:00 Registration & buffet lunch
14:00 Welcome address The President
14:05 – 15:30 Case presentations:
‘Problems in ophthalmic anaesthesia’ Moderators:
Anthony Rubin, London
Steve Mather, Bristol

Delegates are invited to give 5-minute presentations of cases involving significant complications of local blocks, or which present difficult anaesthetic choices

15:30 – 16:00 Tea
16:00 – 16:30 Plenary Lecture Paul Rosen, Oxford
‘The implications for ophthalmic anaesthesia of Independent Diagnostic and Treatment Centres’

16:30 – 17:30 Council Meeting

19:30 Annual Dinner

Friday 28 October

a.m.
08:30 – 09:00 Coffee and Registration
09:00 – 10:30 Scientific session 1
Chronic orbital pain—an anaesthetic perspective Chairman: Steve Mather, Bristol
Chandra Kumar, Middlesbrough
Anaesthesia for paediatric ophthalmic surgery
Idse Herrera, Newcastle
Anaesthesia for ophthalmic trauma
Chris Dodds, Middlesbrough
Regional anaesthesia for ocular adnexal surgery
Richard Downes, Jersey

10:30 – 11:00 Coffee
11:00 – 12:00 Free paper session Chairman: Sean Tighe, Chester
12:00 – 12:30 BOAS annual general meeting

12:30 – 13:30 Lunch

p.m.
13:30 – 15:00 Scientific session 2
New drugs for ophthalmic anaesthesia Chairman: Peter Coleman, Jersey
Hamish Macure, Leeds
Training anaesthetists and surgeons in ophthalmic Chris Dodds, Middlesbrough
regional anaesthesia
Speaker TBC
The future of regional anaesthesia for ophthalmic surgery For: David Smerdon, Middlesbrough - will there be a need in 5 years time? Against: Tom Eko, Norwich
Debate:
‘Is an anaesthetist needed in the theatre suite for all cataract surgery?’

15:00 – 15:30 Tea
15:30 – 16:00 Abbot Lecture
‘New Perspectives in ophthalmic regional anaesthesia’ Jacques Ripart, France
Correspondence

Correspondence No. 1

From: beryl.magrath@ntlworld.com
[mailto:bery.l.magrath@ntlworld.com]
Sent: 01 July 2005 13:31

To: Chandra.kumar@stees.nhs.uk
Subject: Sub-Tenon's block

Dear Chandra

I had my first cataract operation yesterday, as an NHS patient. I am a high myope & had a 7 dioptre lens inserted. I have been an ophthalmic anaesthetist for 16+ years. I retired from F/T practice in the NHS in 2000, but still do a regular weekly eye list. I made some notes on my procedure, which I thought might interest you...

1) My surgeon (for whom I regularly anaesthetise) initially offered me a transfer to Moorfields, but I said that I was quite confident in her & would like her to the operation. She is a first rate surgeon, whose operating technique is exemplary. She does not take any short cuts. She carefully follows up her patients and is also a good caring doctor

2) The Ophthalmic Unit staffs were excellent and went to great lengths to explain things

3) My anaesthetist, was very anxious & proposed that the surgeon did the block! However she persuaded him that I was just another high myope patient

4) The Day Surgery Unit is a modern "Design & Build", which I helped plan, commission and write nurse pre-admission guideline & protocols. Two of the 6 theatres are dedicated ophthalmic theatres

5) Every member of staff wanted to say hello & good luck, thus preventing any anonymity with my fellow patients!

6) The staff attending me explained things to me, as they would any other patient, including the self-administration of drops, for which I was very grateful.

7) My anaesthetist did not use EMLA/ametop (as I do) and the cannula insertion was the most uncomfortable part of the procedure

8) I had 1.5mg of midazolam (I rarely give more than 0.5-0.75mg) & noted that I my respiratory drive was obtunded & I had to remind myself to breathe.

9) The Sub-Tenon's block was fine. My anaesthetist used a disposable Steven's cannula

10) I had a complete optic nerve block, which was somewhat disconcerting, as most of my patients seem to retain some vision

11) I had a delivery tube of O2 attached to my gown (I discussed this with my daughter, an SPR 4, and will change my practice as a result-I normally give O2 via a nasal sponge catheter in the opposite nostril if the sPO2 is less than 94%. She pointed out that the drapes form a tent where with rebreathing the inhaled O2 may fall to 19% - or rise with supplementary O2 to 28%)

12) I listened carefully to my surgeon and was pleased to note that the whole procedure from her point of view was uneventful.

13) I staggered a bit 40 minutes after the 1.5mg midazolam.

14) Monocular vision was OK as this was my non-dominant eye. I cooked a 3 course meal for 4, little or no sympathy for my one-eyed handicap!

15) I had no significant discomfort overnight. I usually take arthrotec 50 with paracetamol for back problems & sciatica, but needed none of the latter. I wondered whether this was a residual beneficial effect of the midazolam.

16) I washed my hair with the dressings on, and managed to keep them reasonably dry

17) I took the eye dressing off & was delighted that not only could I see better than ever before in my life, but everything was "Persil" white-just as my patients had said....

Ophthalmic Anaesthesia News, Issue 12, August 2005
Chandra.kumar@stees.nhs.uk   Website http://www.boas.org
18) My eye drop teaching worked well & the drops went in first go
With all good wishes

Beryl Magrath

Dear Beryl
I am pleased that you are fine but I am not so pleased that you suffered pain during sub-Tenon's cannula insertion. I know from clinical experience and published studies that there is some discomfort during cannula insertion but if enough time is allowed after proxymetacaine and amethocaine both, usually there is very little discomfort. I do not advocate midazolam except in very anxious (and doctor) patients and if used the dose is less than 1mg. Optic nerve function is variable. Majority sees something but some do not. Can I interest you to write a page or two on your personal experience? Our BOAS Newsletter will be published in late August. If you do, please send your write up before mid August.

Best wishes

Chandra

Dear Chandra
I have misled you. It was the IV cannulation, which was most unpleasant. My cornea was well anaesthetised with liberal amounts of proxymetacaine drops, so the sub-Tenon’s block was painless. The other thing I noted was that I had a very stuffy nose, which was quite irritating, overnight-I assume my anaesthetist used a vasoconstrictor, probably dilute epinephrine, I sometimes use this to avoid subconjunctival haematome, but might discontinue this in future.

Best wishes
Beryl

Correspondence No. 2

Hi Sean

I am lead for ophthalmic anaesthesia at Bucks hospitals. We do all our cataracts with peribulbaras as our surgeons like it this way. Could you tell me if there is a BOAS view on what the longest acceptable axial length for sharp needle block is? I have heard plenty of opinions on this, all disagreeing! We had a case of eye injury who sued the Trust and the expert witness then said 27 was the upper limit acceptable.

Thanks

Eve Taylor

Dear Eve,

BOAS does not have an official view on this.

The BOAS meeting in Jersey in October is looking for interesting cases for short presentations and discussion. Can I suggest that you submit the case you refer to and the views of the expert witness. I am sure that a consensus will be then achieved. Go to the BOAS website for details of the Jersey meeting and how to submit your case ([www.boas.org](http://www.boas.org)) or e-mail Bartley MacNeela on mcneela@jerseymail.co.uk.

Regards

Sean Tighe

Correspondence No. 3

Rethinking anaesthesia strategies for patients with open-globe injuries: alternatives to general anaesthesia

Dr Steven Gayer M.D., M.B.A.
Associate Professor of Anaesthesiology and Ophthalmology
Department of Anaesthesiology, Perioperative Medicine, and Pain Management

University of Miami Miller School of Medicine
Director of Anaesthesia Services

Anne Bates Leach Eye Hospital at Bascom Palmer Eye Institute

I enjoyed reading the case report, “Peri/retrobulbar block can be a safe, albeit not routine anaesthesia technique for repair of penetrating eye injuries” in the December issue of the BOAS Ophthalmic Anaesthesia News. Although regional anaesthesia is often a valuable alternative for the management of trauma patients who have recently ingested food or drink, it has traditionally been considered contraindicated in patients with penetrating eye injuries, in part owing to the potential to extrude intraocular contents via force generated by local anaesthetics. Needle instrumentation of the orbit, squeezing of the eyelids, and pressure due to potential haemorrhage are additional reasons regional anaesthesia is typically avoided in open-globe scenarios. Nonetheless, some anecdotal case reports of successful use of ophthalmic blocks in this setting, such as reported in the newsletter, have been published. Recognizing that there are multiple distinct permutations of eye injuries, we have developed techniques to safely block patients with select open-globe injuries. In a five year period, 220 injured eyes were repaired via regional anaesthesia at the University of Miami’s Miller School of Medicine Bascom Palmer Eye Institute. A significant number of injuries were caused by intraocular foreign bodies and dehiscence of cataract or corneal transplant incisions. Successfully blocked eyes tended to have more anterior, smaller wounds than those repaired via general anaesthesia. There was no outcome difference, defined as comparative change of visual acuity from initial evaluation until final examination between the eyes repaired via regional versus general anaesthesia. A more recent retrospective review of open-globe injury cases at Bascom Palmer Institute’s Anne Bates Leach Eye Hospital revealed similar findings. Moreover, combined topical anaesthesia and sedation for selected patients with open-globe injuries has also been reported.

References:

Correspondence No. 4

Dear BOAS members

Ophthalmic Anaesthesia News, Issue 12, August 2005
Chandra.kumar@stees.nhs.uk Website http://www.boas.org
I would like to take the opportunity to thank all BOAS members for supporting me in the recent AAGBI Council election. Without your support, it would not have been possible to secure a win.

Professor Chandra M Kumar
Council Member, BOAS
Dear Miss Barber,

*Logo for the British Society of Ophthalmic Anaesthesia*

As you can see, we are now using the logo you so kindly and skilfully designed for us. We are absolutely delighted with it. On behalf of the Society, I would like to thank you very much indeed for your excellent work and wish you much deserved success in your future design career.

Yours sincerely

Dr Sean Q M Tighe
Consultant Anaesthetist
Secretary, BOAS

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**News and information**

**Newsflash**

**Double Honour for Founding Member of BOAS**

Professor Chandra Kumar has just been elected as a Council member of the Association of Anaesthetists of Great Britain and Ireland in a highly competitive field. Within a week he has also been appointed as the Bernard Johnson Advisor for Overseas Doctors to the Royal College of Anaesthetists. This is one of the highest appointable posts within the RCA and one which plays a key role in many of the activities of the College.

It is a great accolade to Chandra and a fitting reward for his hard work and vision, which is also evident in his drive to create the BOAS and in acting as its first secretary. I know that he will focus his efforts within
these two roles to the greater benefit of anaesthesia in general and for ophthalmic anaesthesia in particular.
I am sure that I can speak for all of us in offering our congratulations on this dazzling double achievement.

Chris Dodds
President

Newsletter
BOAS Newsletter will be available on the BOAS website (www.boas.org). It may be possible to send the newsletter in PDF format provided we have your current email address. To make this facility more effective, please make sure to update your email address and inform the secretary of BOAS.

OASIS (OAS Newsletter)
Printed version of OASIS is not available. Please visit OAS website (www.eyeanaesthesia.org)

No subscription for retired members
Retired members do not need to pay the annual subscription fee.

Income Tax Rebate to Society Members
BOAS is registered with Her Majesty’s Inland Revenue for the purposes of Corporation Tax. Members can claim income tax allowance against the BOAS subscription.

Contribution for the 13th issue
The next Newsletter will be published in March 2006. Please send your articles or any contributions for inclusion in the Newsletter by 30th March 2005 to Professor Chandra Kumar, Editor Ophthalmic Anaesthesia News, The James Cook University Hospital, Middlesbrough TS4 3BW, UK or email chandra.kumar@stees.nhs.uk

Subscription to Journal of Cataract and Refractive Surgery
Anaesthetic members of BOAS can receive the journal at a discounted rate of £65 by writing to Andre Welsh, UKISCRS, PO Box 598, Stockton on Tees TS20 1WY. Tel 01642651208, Fax 01642651208, Email: ukiscrs@onyxnet.co.uk, Website: www.ukiscrs.org.uk

BOAS database management
Mrs Pat McSorley maintains the BOAS membership database since 1998 but has now retired. She continues to administer and maintain the membership database from her home.

Reasons for joining BOAS
BOAS was formed in 1998 to provide a forum for anaesthetists, ophthalmologists and other professionals with an interest in ophthalmic anaesthesia to facilitate co-operation on all matters concerned with the safety, efficacy and efficiency of anaesthesia for ophthalmic surgery. It is concerned with education, achievement of high standards, audit and research. BOAS will organise annual scientific meetings, produce a newsletter and maintain a web page.
Membership
Membership of BOAS includes anaesthetists, ophthalmologists and other professionals with an interest in ophthalmic anaesthesia.

Membership subscription
Membership runs from January each year. The current subscription is £25.00 payable by banker’s standing order.

Liaison and specialist professional advice
With the Association of Anaesthetists of Great Britain and Ireland and the Ophthalmic Anesthesia Society of the USA.

Benefits of Membership
• Opportunity to participate in BOAS annual scientific meetings
• Reduced registration fee for BOAS annual scientific meetings
• Reduced registration fee for other ophthalmic anaesthesia meetings and courses in UK
• Free advice from experts on matters related to ophthalmic anaesthesia
• BOAS newsletter and Directory of Members
• Opportunity to contribute towards development and improvement of ophthalmic anaesthesia
• Access to BOAS web page and scientific literature database
• Eligibility for election to Council of BOAS

Administrative Office and Membership information from
Web address
http://www.boas.org

Change of address
Members are advised to inform the secretary if there is a change of email or postal address.
Dr. Sean Tighe
Secretary, BOAS
Dept. of Anaesthesia
Countess of Chester Hospital
Liverpool Road, Chester CH2 1UL
Email: sean.tighe@coch.nhs.uk

BOAS Executive Committee
Immediate Past President
Dr Robert Johnson
President
Professor Chris Dodds
President Elect
Mr. Ken Barber
Secretary
Dr. Sean Tighe
Treasurer
Mr Timothy C Dowd

Council Members
Mr. Louis Clearkin
Mr. Tom Eke
Dr. Monica Hardwick
Dr K L Kong
Professor Chandra Kumar
Dr Stephen Mather
Mr Bartley McNeela
Dr. Hamish McLure
Mr. David Smerdon
Dr Guri Singh Thind
ALL AGES ALL STAGES

Sevoflurane
FROM INDUCTION TO MAINTENANCE

SEVOFLURANE

PRESCRIBING INFORMATION

Presentation: Amber vials containing 200ml sevoflurane.

Indications: For induction and maintenance of general anaesthesia in adults and paediatric patients for inpatient and outpatient surgery.

Dose: 1MAC when administered to unanaesthetised children of various age levels.

Summary of Product Characteristics: Induction: In adults, up to 5% sevoflurane usually produces surgical anaesthesia in less than 2 minutes. In children up to 75% sevoflurane usually produces surgical anaesthesia in less than 2 minutes. Up to 2MAC sevoflurane can be used for initiation and maintenance of anaesthesia in unpremedicated patients. Maintenance concentrations range from 0.5-2%.

Elderly: Lower concentrations are recommended.

Administer: Deliver via a vaporiser specifically calibrated for use with sevoflurane. Induction can be achieved and maintained maintained by facemask or endotracheal tube.

Centre-Intoxicating: Sensitivity is broad-based. Known or suspected genetic susceptibility is inadvisable.

Precautions: For use only by trained anaesthetists. Hypersensitivity and respiratory depression occur as anaesthesia is deepened. Monitor hypertensive response with respect to induction. Untoward effects may be seen immediately after administration. Hypotension and hypothermia may occur with narcotics, sedatives, and analgesics. Hypoventilation has been reported rarely. Sevoflurane may cause adrenal failure, particularly in children. Rare reports of adverse reactions, such as rash, urticaria, pruritus, bronchospasm, anaphylactic or anaphylactoid reactions, have been reported. Sevoflurane should be avoided in patients with known sensitivities.

Use in Pregnancy and Lactation: Use during pregnancy may only be considered in women who need induction and maintenance of anaesthesia. Sevoflurane is not recommended for use in pregnancy.

Special Storage Conditions: Do not store above 25°C. Do not refrigerate. Use by expiry date.

Legal Category: POM

Ophthalmic Anaesthesia News, Issue 12, August 2005
Chandra.kumar@steehs.nhs.uk Website http://www.boas.org
**British Ophthalmic Anaesthesia Society Member Registration Form**

**STANDING ORDER MANDATE**

**Postal Address of your bank:** .................................................................

**Please Pay**

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<tr>
<th>Bank</th>
<th>Branch Title (not address)</th>
<th>Sorting Code Number</th>
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<tbody>
<tr>
<td>Midland Bank</td>
<td>South Cleveland Hospital Branch</td>
<td>4 0 3 3 0 1</td>
</tr>
</tbody>
</table>

**Beneficiary's Name**

**Account Number**

**Quoting Reference**

**for the credit of**

British Ophthalmic Anaesthesia Society

**Amount**

**Amount in words**

**the sum of**

£25.00

**Twenty Five Pounds every year**

**Date of first payment**

**Due date and frequency**

**and thereafter every**

**Yearly**

**Date of last payment**

**and deduct my/her account accordingly**

**PLEASE CANCEL ALL PREVIOUS STANDING ORDER/ DIRECT DEBIT MANDATES IN FAVOUR OF**

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<th>UNDER REFERENCE NUMBER</th>
<th>Account to be debited</th>
<th>Account Number</th>
</tr>
</thead>
</table>

**Special instructions**

**Signature(s).**......................................................................................................................... Date.

**Banks may decline to accept instructions to charge Standing Orders to certain types of account other than Current Accounts**

**NOTE:** The Bank will not undertake to

a) make any reference to Value Added Tax or pay a stated sum plus VAT, or other indeterminate element.
b) advise remitter's address to beneficiary.
c) advise beneficiary of inability to pay
d) request beneficiary's banker to advise beneficiary of receipt.
e) accept instructions to pay as soon after the specified date as there are funds to meet the payment, if funds not available on the specified date.

Payments may take 3 working days or more to reach the beneficiary's account. Your branch can give further details.

**Personal details**

**Last name (Dr, Mr, Mrs, Miss, Ms).**................................................................. **First Name.**

**Department.**.......................................................................................................................... **Institution.**

**Address.**.................................................................................................................................

**City/County/...**................................................................. **Post code.**

**Phone.**.............................. **Fax.**.............................. **Email.**..............................

**If you would like to become a member of the British Ophthalmic Anaesthesia Society, please complete the bank standing order and your personal details.**

**Completed form should be sent to:-**

Dr. Sean Tighe
Secretary, BOAS
Dept. of Anaesthesia
Countess of Chester Hospital

Ophthalmic Anaesthesia News, Issue 12, August 2005
Chandra.kumar@stees.nhs.uk  Website http://www.boas.org
Local Anaesthesia for Ophthalmic Surgery

Friday, 17th February 2006, Middlesbrough

A CME approved meeting for anaesthetists and ophthalmologists on Local Anaesthesia for Ophthalmic Surgery will be held in the Education Centre, The James Cook University Hospital, Middlesbrough on Friday, 17th February 2006. The meeting will include lectures and live demonstration of orbital blocks. Attendance is limited to 50 participants. Application form and information from Mrs Elaine Tucker (Course Administrator 01642-854601 email: elaine.tucker@stees.nhs.uk. Registration fee is £250 (BOAS Members £225) (inclusive of catering). Cheque payable to Ophthalmic Anaesthesia Education Trust Fund.
PROVISIONAL PROGRAMME

09.00 - 09.25 Registration

09.25 Welcome: Professor Chris Dodds, Middlesbrough

Chairman: Dr Robert Johnson, Bristol

09.30 - 10.15 Anatomical considerations for ophthalmic block

Mr David Smerdon, Middlesbrough

10.15 - 11.00 Pharmacological considerations for ophthalmic block

Dr Hamish McLure, Leeds

11.00 - 11.30 Coffee break

Chairman Dr A P Rubin, London

11.30 - 12.00 Akinetic anaesthesia for eye surgery

Professor Chris Dodds, Middlesbrough

12.00 - 12.30 Non-akinetic anaesthesia for eye surgery

Professor Ezzat Aziz, Egypt

12.30 - 12.45 Teaching eye blocks

Dr Dave Murray, Middlesbrough

13.00 - 13.45 Lunch

13.45 -16.15 Live demonstration of orbital blocks

Demonstration co-ordinators: Dr Anthony Rubin, Dr Robert Johnson,
Professor Chandra Kumar, Mr Chrisjan Dees, Mr Sam Gerges, Mr David
Smerdon & Professor Chris Dodds

Retro and/ or peribulbar Prof Chandra Kumar, Middlesbrough

Dr Anthony Rubin, London

Dr K L Kong, Birmingham

Recorded video Professor Ezzat Aziz, Egypt

Sub-Tenon’s

Posterior sub-Tenon’s block Prof Chris Dodds, Middlesbrough

Dr Hamish McLure, Leeds

Mid sub-Tenon’s block Dr Raju Chabria, Middlesbrough

Meeting organiser: Prof Chandra Kumar, Course director: Prof Chris Dodds, Academic Department of Anaesthesia, The James
Cook University Hospital, Middlesbrough TS4 3BW. Tel: 01642-854601, email: chandra.kumar@stees.nhs.uk